Anxiety and Worry as Aspects of Normal Behavior

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• **Anxiety and worry are not necessarily psychopathological reactions. Anxiety is a basic physiological and affective response to the perception of danger. Worry is an effort to deal with the perceived threat at an intellectual level. Realistic anxiety and worry, based on objective and realistic dangers, should be distinguished from neurotic anxieties and worries.**

Within certain limits realistic anxiety and worry are useful adaptive mechanisms which enable a person to cope more effectively with anticipated dangers. Excessive anxiety and worry, however, or the absence of these reactions in circumstances where they would be appropriate, both tend to lead to maladaptive responses. These considerations have certain useful implications in medicine, notably in the preparation of patients for surgical operation.

ONE OF THE COMMONEST misconceptions about human behavior is that anxiety and worry are always abnormal. "How to Get Rid of Anxiety," or "How to Stop Worrying" are favorite topics in the countless self-help books, magazine articles and newspaper columns which constantly exhort the American public on the means of achieving a better life. It is an extraordinary fact that even the psychiatric and psychological professions, which should know better, have done almost nothing to dispel this misconception and, indeed, in many instances have contributed to its perpetuation.

The purpose of this communication is to review briefly a few ideas about the nature of anxiety and worry, and to indicate that within certain limits these phenomena are significant and essential aspects of normal human behavior. Let us begin with some basic definitions.

One of the fundamental principles which underlie all human activity is the need of the organism to maintain homeostasis with regard to both its internal and its external environment. When homeostatic control is threatened, the organism is mobilized into adaptive efforts at regaining control. Anxiety refers to the *signal* of present or future danger with which the ego seeks to mobilize all the organism's resources in the interests of defense, self-preservation or the restoration of homeostasis.

The differentiation between anxiety and fear has been a source of frequent discussion in the psychiatric literature, and there is no uniform agreement about it. In general, the term *fear* is used to refer to reactions to known, tangible and objective dangers, while the term *anxiety* is reserved for reactions to unknown, intangible and subjective ones. Fear, moreover, most often refers to present dangers, while anxiety is more apt to refer to anticipated or future ones. Actually, a sharp line of distinction between them is not always possible even on the basis of the above criteria. Physiologically, moreover, there is no difference between fear and anxiety. In both, the organism mobilizes the same autonomic and humoral resources to facilitate either "fight or flight."

Although laymen often use the terms *anxiety* and *worry* interchangeably, in actuality they represent quite different orders of responses to danger. Anxiety is a primitive, basic, physiological and affective response to the perception of danger. Worry, on the other hand, can be characterized as a kind of apprehensive thought which is mobilized by anxiety, and which represents an effort on the part of the organism to cope with the anticipated danger.[2] Anxiety is an emotional signal, an alerting mechanism. Worry is a form of mental activity, an effort at problem-solving. It must be emphasized, however, that although worry differs in nature from anxiety, it never exists without anxiety. The mental work of worry is always triggered by and associated with underlying feelings of anxiety. It is undoubtedly for this reason that they are so often confused with one another.

Let us now return to our topic of anxiety and worry as aspects of normal human behavior.

Anxiety can be conceived of as being at the end of a long evolutionary chain which goes all the way back to protoplasmic irritability and animal vigilance. As a psychological reaction it is comparable to its physiological analogue, the sensation of pain. Both are signals to the organism that something is threatening its integrity, and both are essential alerting mechanisms which enable the organism to make the proper adaptive responses. Just as an individual lacking the capacity to feel pain would be seriously handicapped, so also would be an individual who was incapable of reacting with anxiety. On the other hand, if too much pain is present, it can actually interfere with the organism's ability to deal

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with the noxious stimuli. Thus, what normally serves as an essential protective device can, if it becomes excessive, act as a destructive influence or a kind of disease in itself. The same is true of anxiety. In mild or moderate form it acts as a constructive force, spurring the ego on to make adaptive attempts at mastering the actual or potential threat to its safety. Thus, moderate anxiety has been shown to facilitate learning. If the ego's efforts at mastery fail, however, then the anxiety increases to a point where it in itself becomes a handicap to the ego's adaptive efforts. In extreme form, anxiety may cause total disorganization or paralysis of ego activity. We see examples of this in panic reactions, in agitated depressions, and in catatonic excitements. Examples of the pathological absence of anxiety can be seen in "la belle indifference" of the classical hysteric, in the flattened emotions of the hebephrenic, and in the apathetic reactions of certain psychotic depressives. We also see it in everyday life in the reaction of *denial,* in which a person represses or denies the existence of a threat—a kind of psychological equivalent of the ostrich's supposed act of burying its head in the sand when threatened. We shall have more to say about this mechanism later on.

Even moderate anxiety can be pathological if its real sources are repressed and unconscious. Such anxiety appears in the form of so-called "free-floating anxiety" or "nameless dread" with which the ego is powerless to cope since it is unable to identify the repressed threat which is provoking the anxiety. Similarly, when the anxiety is displaced from its real origins to some substitutive object, as in the phobias, the ego is also unable to effectively cope with the repressed threat. In normal anxiety, however, the threat, whether immediate or anticipated, is realistic and conscious, and the ego is mobilized into efforts at preparing for it or coping with it.

REALISTIC WORRY

Worry represents such a coping effort at the intellectual level. Realistic worry is based on realistic anxiety—that is, it is related to realistic danger, immediate or anticipated. Although at times it may at first glance seem to be related to a past traumatic experience, closer analysis will usually indicate that what the worried ego is struggling with are the present or future consequences of the experience. Thus a student who is worrying about having failed an important examination is really concerned with what is going to happen to him as a consequence of the failure.

Successful worry leads either to action designed to cope with or eliminate the threat which has provoked the underlying anxiety, or else to a new homeostatic equilibrium in which the individual intellectually adapts to the threat and is able to live without being distressed by it any longer. An example of the first reaction would be the student whose worry over his poor showing in an examination spurs him into harder and more effective study to compensate for his poor grade. An example of the second reaction would be the student who finally makes his peace with the fact that he is not going to be an outstanding scholar and sets his sights more realistically.

NORMAL ANXIETY USEFUL IN MEDICINE

Normal anxiety and worry have special significance in medicine and surgery. Preventive medicine rests on a foundation of realistic anxiety and anticipatory concern. Without it, people would be less likely to undergo prophylactic inoculations and periodic health examinations, or to watch their diets, or to give up any immediate pleasures in the interest of a long-range health program.

In surgery the problems of realistic anxiety and worry have a particular importance. Internists and surgeons have long been aware that the mental attitude of a patient about to undergo a serious operation seems to have a significant effect not only on the postoperative course but even upon his ability to tolerate the surgical procedure itself. This has led to efforts at preoperative "psychic buffering," particularly in the form of the routine administration of barbiturates on the night before operation. On the purely psychological level, surgeons generally try to cope with the patient's anxieties by administering liberal doses of reassurance, or by minimizing the seriousness of the imminent procedure: "Don't worry about a thing—just leave the worrying to me," or "It's nothing at all—you'll be up and walking around in three or four days."

The underlying assumption in these approaches is that it is bad for the patient to be worrying about the anticipated operation. On the other hand, if what I indicated in earlier paragraphs has any validity, the conclusion seems justified that it would be just as unhealthy for a patient not to worry at all about a serious surgical procedure as it would be for him to worry too much. A number of studies have been done in recent years which indicate precisely this. One of these studies, by Janis of Yale University,[1] is particularly pertinent. Janis studied a group of 23 patients before and after their undergoing major surgical operation and found that they fell into three broad groupings, according to their anxiety levels:

1. Patients with extremely high preoperative anxiety, who were constantly worried and agitated, could not sleep and could not be reassured. Their

excessive fears of body damage were linked with many clinical signs of chronic neurotic disturbances which could be traced back to early life experience. Patients in this group were more likely than the others to show excessive anxiety postoperatively also.

2. Patients with moderate anticipatory anxiety, who were occasionally tense or agitated and worried about specific features of the operative procedure or anesthesia, but who tended to be relieved when given authoritative reassurance. Patients in this group were significantly less likely than the others to have postoperative emotional disturbances.

3. Patients with little or no anticipatory anxiety, who were constantly cheerful and optimistic, denied any concern or worry, slept well and showed no observable evidences of tension. Patients in this group were more likely than the others to display postoperative reactions of intense resentment and irritability.

CONSTRUCTIVE WORRY

These and similar observations confirm the proposition that a moderate amount of anxiety and worry over an anticipated real trauma is normal and enables a person more effectively to cope psychologically with the traumatic experience. This is important in helping us to know what kind of psychological communications we can make to patients to help them in their coping efforts—to help them worry constructively, so to speak. Thus it is not helpful to a patient to be told he is not going to experience any pain or other difficulties if in fact he is. It is far better to give him a reasonable idea of what he can expect as well as what will be done to help him. The anticipatory anxiety which he thus experiences enables him to be better prepared psychologically to cope with the difficulties when they do occur. On the other hand, if an individual fails to do this "work of worry" in response to an anticipated danger, and instead falls back on the mechanism of denial, this defense will tend to break down when the danger or suffering actually occurs, and intense feelings of helplessness, panic or rage then tend to ensue.[3]

This is one of the reasons, incidentally, why unexpected traumas are much more apt to cause emotional disturbances than are expected ones. In the former there is no opportunity for realistic anticipatory anxiety and worry on the part of the ego which would enable it to prepare its defenses for the danger when it arrives.

In conclusion, a question may properly be asked as to the practical significance of recognizing that realistic anxiety and worry are aspects of normal, indeed healthy, human behavior. My reply would be that such recognition not only may lead to the elimination of unwarranted feelings of guilt and self-depreciation in people, but also to more therapeutic psychological attitudes and communications on the part of physicians or other authority figures toward people with such anxiety. We had a dramatic verification of this on a large scale in the experiences of the past two World Wars. The recognition and teaching that fear is a normal human reaction under conditions of danger was of enormous help in maintaining the morale of many soldiers in World War II, who were thus relieved of the enormous additional burden of guilt and social condemnation which their predecessors in World War I experienced when they felt afraid. By the same token, I believe that the misconception that worry of any kind is abnormal is responsible for widespread tension in many intrapersonal and interpersonal situations. Many people are apparently unaware of the fact that to be unworried in the face of a threatening reality situation may be a sign of mental disorder rather than of mental health.

This also has implications in relationship to the prescription of tranquillizing drugs. Without in any way minimizing the invaluable contribution which these drugs have made in the management of severe mental illness, it is important to recognize that their use is logically indicated only where there is excessive anxiety, not realistic anxiety. To block out a patient's realistic anxiety would be to deprive him of an essential part of his adaptive apparatus. Where real problems exist, the task of the physician, whenever possible, is to help the patient face these problems objectively and cope with them constructively. The difference between mental health and neurosis lies not in the absence of problems but in the ego resources which a person is able to bring to bear on the problems which always exist; not in the absence of anxiety, worry or grief, but in whether or not these reactions have a realistic basis and whether or not they ultimately lead to constructive coping activity on the part of the human organism.

HEALTH AND HAPPINESS NOT SYNONYMOUS

All too often psychiatric patients have the illusion that mental health and happiness are synonymous, and that when they are "cured" they will "live happily ever after." Obviously even the most successful psychotherapeutic procedure cannot guarantee happiness for anyone. The world in which we live presents us with a continuous succession of real problems and difficulties. Even if our personal lives are momentarily free from stress, the world at large never is. We would be less than healthy if we did not all share some concern about, for example, the current state of our planet.

One of the challenges which confront modern man, probably more than any of his forebears, is

the necessity of living with continuous uncertainty and tension. Shorn of his belief in his immortality, shaken in his faith in a personal and protective God, faced with the prospect of living on the brink of nuclear extinction for an indefinite time to come, modern man cannot but live in a state of constant "existential" anxiety. This is part of the price we pay for being human, but it is a price worth paying for the freedom that comes with self-awareness.

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REFERENCES

1. Janis, I. L.: Emotional Inoculation: Theory and Research on Effects of Preparatory Communications, in Psychoanalysis and the Social Sciences, International Universities Press, Inc., New York, 1958, pp. 119-1954.
2. Marmor, J.: The Psychodynamics of Realistic Worry, in Psychoanalysis and the Social Sciences, International Universities Press, Inc., New York, 1958, pp. 155-162.
3. Marmor, J.: Psychological Preparation of Patients for Major Surgery, Rounds of the Teaching Staff, Journal of the Wadsworth General Hospital, Vol. 4, No. 7, March 1961, pp. 303-308.

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